AIR WAR COLLEGE

AIR UNIVERSITY

THE MILITARY HEALTH SYSTEM:

REDEFINING THE ROLE OF EMPLOYERS AND

IMPROVING COST-SHARE PARITY AMONG RETIREES

by

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Biography

Lieutenant Colonel William P. Malloy is a student at the Air War College (AWC), Air University, Maxwell AFB, AL. Prior to attending AWC, Colonel Malloy commanded the 509th Medical Support Squadron at Whiteman AFB, MO. He has held numerous positions of increased responsibility at four Military Treatment Facilities (MTFs), the Office of the Air Force Surgeon General and the Office of the Air Force Deputy Chief of Staff for Strategic Plans and Programs, at the Pentagon, where he helped build and defend the United States Air Force five-year, $638 billion program.

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Colonel Malloy has deployed twice; first as the Administrator of the Air Force Theater Hospital, Prince Sultan Air Base, Saudi Arabia in 2002-2003 and then as the Chief of the Medical Control Center, Joint Base Balad, Iraq, in 2008. He is board-certified in health-care management and a Fellow of the American College of Healthcare Executives.

Abstract

The cost of military health care has almost tripled over the last decade from $19 billion in 2001to $53.5 billion in 2012 and is approaching 10% of the defense budget. This unprecedented growth, and the huge cuts to the overall Department of Defense (DoD) budget, is driving strategic tradeoffs between competing defense priorities, including how much the DoD can afford to pay for health care. The DoD has repeatedly proposed higher enrollment fees in order to help offset health-care costs and modify beneficiary utilization behavior, but it has been unable to secure approval through Congress. Most experts agree fundamental reform to the Military Health System (MHS) is needed, but few offer concrete, politically viable options.

This paper will analyze and evaluate the costs, benefits and policy implications associated with redefining the role of employers of working military retirees and improving cost-share parity among retirees. Specifically, I recommend employers be required to pay TRICARE the insurance premium they would have otherwise had to pay to their insurance carrier if the retiree opts out of the employer plan. Just as important, I propose DoD leave the baseline TRICARE fees alone, but charge an additional fee to working-age retirees based on a percentage of wages above retirement pay. This will require changes to Section 707 of the 2007 NDAA as it relates to employers providing payments to retirees for opting out of employer-sponsored health insurance coverage.

Implementing these proposed options could provide the MHS an additional $48 billion in revenue across the Future Years Defense Program (FYDP, FY 2015-2019). In this period of fiscal austerity, I fear significant cuts to the MHS could have unintended, long-lasting, negative impacts to military readiness. The funding provided through my proposal has the potential to maintain the current benefit and provide additional time for deliberate strategic planning.

Introduction

Can the Department of Defense (DoD) continue to provide health care benefits to a growing number of beneficiaries without increasing baseline TRICARE fees? The DoD has repeatedly proposed new or increased fees in order to help offset health care costs and modify beneficiary utilization behavior, but it has been unable to secure approval through Congress. The cost of military health care has almost tripled over the last decade from $19 billion in 2001 (6% of DoD budget) to $53.5 billion in 2012 (8% of DoD budget). This unprecedented growth, and the huge cuts to the overall DoD budget, is driving strategic tradeoffs between competing defense priorities, including how much the DoD can afford to pay for health care. *Instead of proposing increases to baseline TRICARE fees, the DoD should propose policies that direct employer payments to TRICARE for working-age retirees and promote increased cost-share parity among working retirees with respect to wages above retirement pay.*

This paper is organized into six sections. First, I describe how DoD provides the benefit through the TRICARE program. Second, I outline the cost of military health care and challenge the popular rhetoric that suggests health care costs are out of control. Next, I describe several efforts the DoD has implemented to maintain the status quo. Fourth, I describe the minimal role employer's play today and how the DoD is currently underwriting and supporting fiscal policy that is inconsistent with Congressional intent. Next, I outline three policy options that DoD could pursue instead of increasing baseline TRICARE fees. Finally, I recommend two options that could generate over $48 billion across the Future Years Defense Program.

How DoD Provides the Benefit

Organic Capability Augmented by Contracts

The MHS direct care system includes 56 hospitals and 361 clinics that serve almost 10

million beneficiaries.[1] It provides a global network that employs approximately 86,000 military personnel and 68,000 civilians.[2] Direct care costs include the provision of medical care directly to beneficiaries, the administrative requirements of a large medical establishment, and maintaining a capability to provide medical care to combat forces in the field. Private Sector Care (PSC), conversely, includes civilian providers under contract to DoD through TRICARE regional contracts for care provided outside DoD medical facilities.[3]

The DoD provides health-care benefits to military active duty, retiree, Guard, reserve and their dependents through the TRICARE program utilizing both direct care and private sector care systems. In general, TRICARE has four main benefit plans that vary based on the relationship to a sponsor, sponsor's duty status, and location: a health maintenance organization option (TRICARE Prime), a preferred provider option (TRICARE Extra), a fee-for-service option (TRICARE Standard), and a Medicare wrap-around option (TRICARE for Life) for Medicare-eligible retirees.[4] Other TRICARE plans include the Uniformed Services Family Healthcare Plan,[5] TRICARE Plus, TRICARE Young Adult, TRICARE Reserve Select, and TRICARE Retired Reserve. TRICARE also includes a pharmacy program and optional dental plans.

Active-duty military members are automatically enrolled into TRICARE Prime and are assigned to a military treatment facility (MTF). If an active-duty member and his or her family live more than 50 miles from an MTF, they are enrolled to a civilian primary care manager under TRICARE Prime Remote.[6] All other beneficiaries are free to choose among the plans for which they are eligible and that best suits their needs (with some restrictions related to maximizing enrollment at MTFs). Military retirees under age 65 can choose TRICARE Prime if they live close to an MTF (usually 30 miles—commonly referred to as the PSA, or Prime Service Area). If a retiree lives outside of the PSA then the retiree and his or her family are automatically covered

by TRICARE Standard or TRICARE Extra.

Funding the Benefit – The Unified Medical Program (UMP)

Annual funding for military health care can be divided into two major components: the Defense Health Program (DHP) and Military Personnel.[7] The annual defense appropriation act, under the Defense Health Program, provides funding to the DHP for health-related operations and maintenance (O&M); procurement; and research, development, test, and evaluation (RDT&E). Most of the resources appropriated for military health care are allocated to DHP. The same appropriation act, under the Military Personnel program, also includes funding for the pay and benefits of uniformed personnel who work in the health-care system, and for accrual payments on behalf of all military personnel to fund military health-care for those who retire and become eligible for Medicare.

In addition to those two major categories, funding for the construction or replacement of military hospitals, clinics, or other facilities is provided in the annual military construction and veterans affairs appropriation act.[8] For example, Figure 1 below shows the 2014 UMP request. As you can see, O&M, pay and benefits of military personnel working in DoD healthcare, and accrual payments represented 95% of military health-care funding. Excluded from the UMP is service ("line") funding for medically related personnel and services such as embedded medical personnel (Army/Navy), squadron medical elements (Air Force), the drug demand reduction program and specific mental-health-related programs.

Unless explicitly stated, any reference to military health expenditures in this paper includes the grand total of all of the components of the annual UMP appropriation.

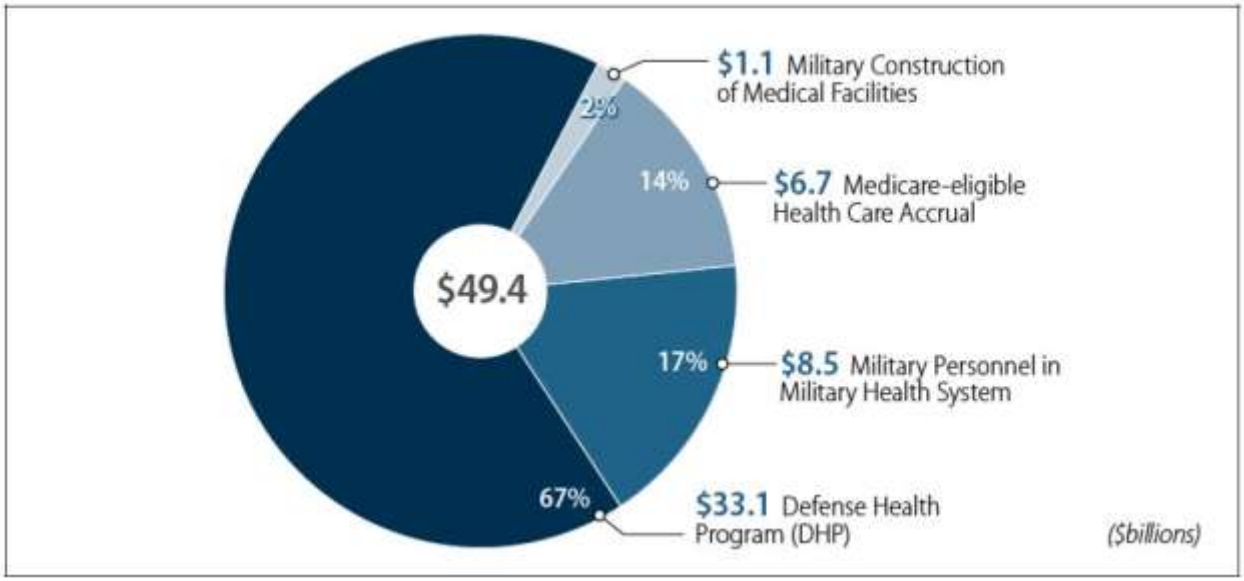

Figure 1. FY2014 Unified Medical Program Request ($billions)[9]

The Cost of Military Health Care

Are Health Care Expenditures Really Growing Faster Than other DoD Expenditures?

The cost of providing health care to military active duty, retired, Guard, reserve and their dependents has grown substantially for more than a decade. From 2001-2012, total health-care expenditures increased on average 11 percent per year while the rest of the DoD budget increased around 7 percent per year. However, contrary to the popular rhetoric on the topic, MHS cost growth since FY 2003 *is slightly less* (6.94%) than the rest of DoD (6.98%).[10,11] Cost-growth comparisons starting at 2001 include the effects of the new TRICARE for Life benefit mandated by Congress that greatly inflates the average annual rate of growth.

Declining DoD Budget Also Skews Perceived 'Out-of-Control' Health Care Cost Growth

The Office of Management and Budget (OMB) projects health care expenditures to grow from 8.2% of the DoD budget in 2012 to 10% by 2018.[12] However, this increase is due, in large part, to the decrease in the DoD budget, and not because of 'out-of-control' health care growth. For example, the DoD budget decreased from 20% of the federal budget in 2010 to 18% in 2012

and is projected to be only 13% of the federal budget by 2018.[13]

Maintaining the right perspective when faced with difficult choices is essential to strategic decision-making. Relative to theoretical alternatives, I suggest the MHS is relatively efficient (appendix A) so changes must be deliberate. Figure 2 below shows the share of the

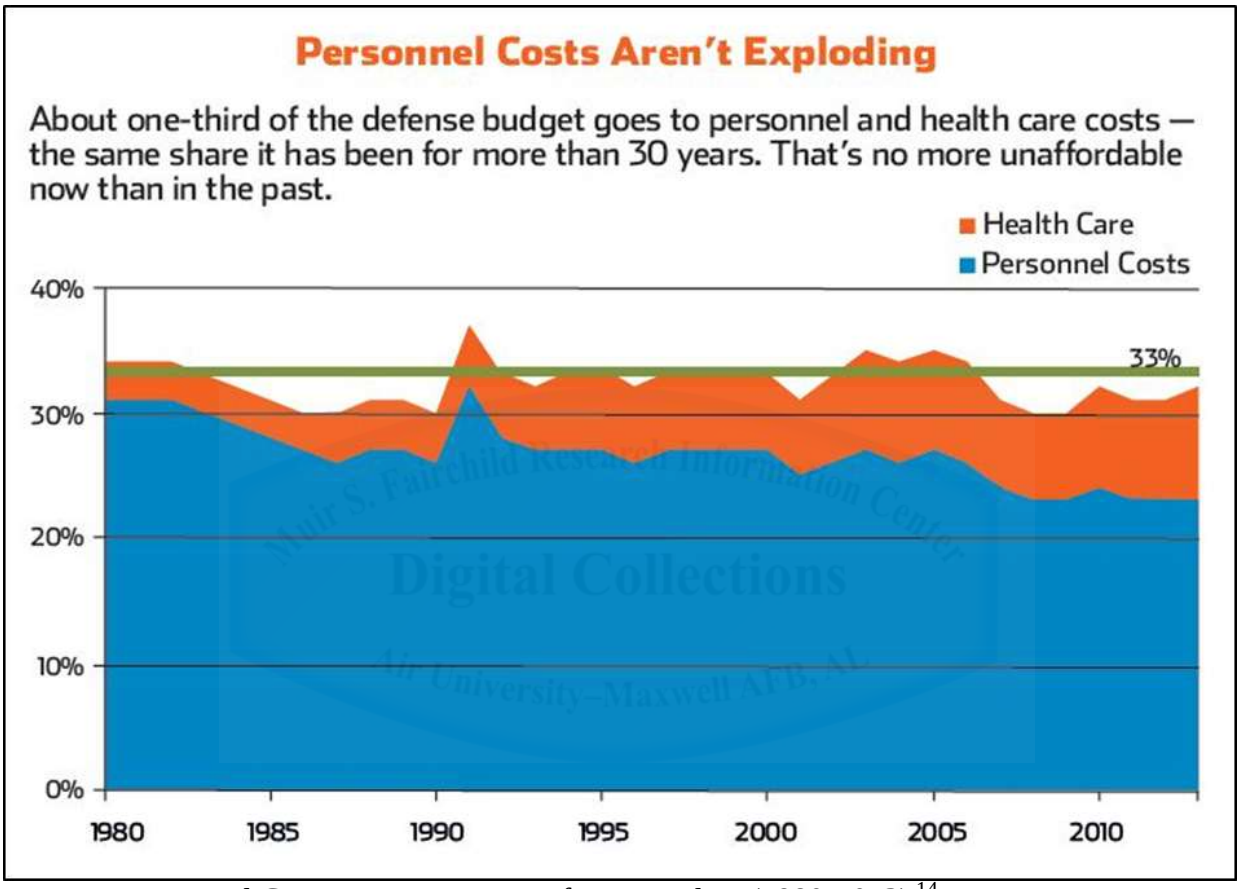

Figure 2. Personnel Costs as a Percentage of DoD Budget (1980-2013) [14]

defense budget spent on personnel costs and health-care since 1980. There is no denying the cost of military health-care in absolute terms has increased, but it isn't any more expensive now relative to what we have paid in the past. Retired Air Force Colonel Mike Hayden of the Military Officers Association of America (MOAA) provides a convincing analysis that about one-third of the Defense budget currently goes to personnel and health-care costs—and that share has not changed significantly for more than 30 years.[15]

Similarly, the Tricare Management Activity states that UMP expenditures as a percentage

of the Defense budget have remained constant at about 7.1% since 2004.[16] If this is true, then what is all the consternation about medical expenses? The concern is related to projected decreases in the DoD budget that will drive cost-cutting behavior at the Pentagon; especially in functions perceived as ancillary to the primary mission. Defense Secretary Chuck Hagel said the greatest threat to the military is "the growing imbalance in where that money is being spent internally."[17]

Growing Concern: Retirees Opting Out of More Expensive Private Health Insurance

An important component of the change in military health-care expenditures is the increased reliance on TRICARE by retirees. Figure 3 below shows the trend in the reliance on TRICARE by eligible retirees under age 65—commonly referred to as working-age retirees. Between FY 2001 and FY 2012, 25.7 percent of retirees switched from private health insurance to TRICARE as the sole payor of health care services. Most of these retirees likely switched because of the increasing disparity between civilian and TRICARE cost-shares.[18] For example, in constant FY 2012 dollars, private health insurance premiums increased by $1,642 (67%) from FY 2002 to FY 2012, whereas the TRICARE Prime premium actually declined by $68 (12%).[19] This provided a strong financial incentive for retirees to make the switch or not seek other health insurance. Unless measures are taken to change this situation, DoD can expect more military retirees to drop other health insurance and rely solely on TRICARE. Finally, in addition to increased utilization rates, the increase in congressionally mandated benefits is responsible for more than 50% of the increased costs.

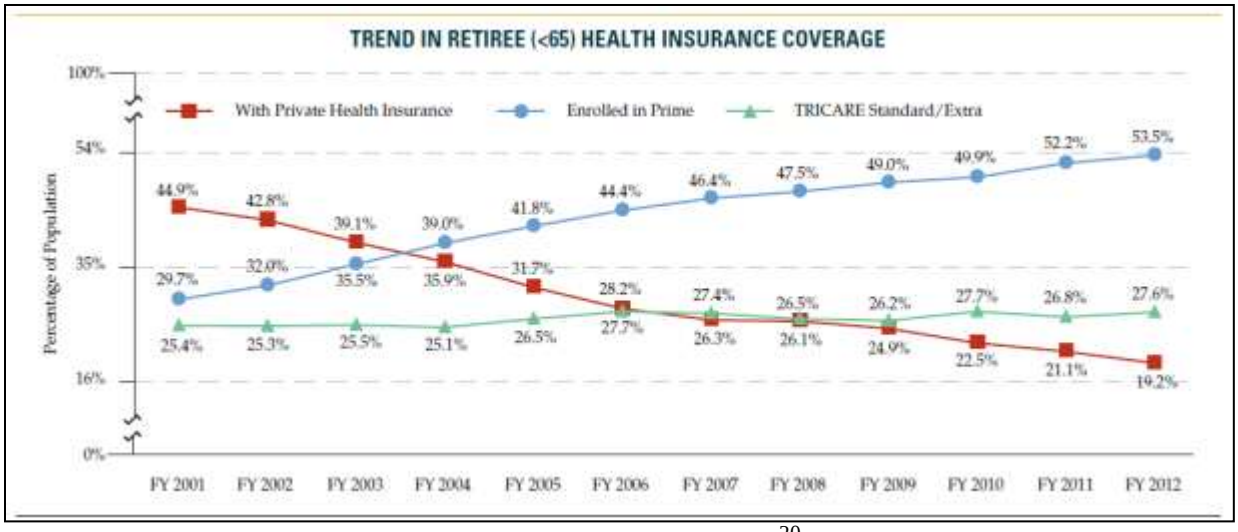

Figure 3. Trend in Retiree (<65) Health Insurance Coverage.[20]

Fiscal Pressure on DoD Forcing Strategic Tradeoffs

As the DoD navigates through future programming and budgeting cycles, health care (especially for military retirees) will undoubtedly be targeted. The DoD faces nearly one trillion dollars in projected spending cuts over the next decade[21] or roughly 10%. Applying that percentage to the MHS would drive a proportional bill of about $5 billion. To pay the bill, the MHS needs to reduce costs, increase revenue or implement some combination of both strategies.

Efforts to Maintain the Status Quo

Changes in Governance, Eligibility and Cost-Shares

In the last five years, the DoD has taken steps to control health-care costs. For example, in 2007 the Task Force on Military Healthcare proposed 12 broad recommendations to sustain the benefit, including reforming MHS governance.[22] The DoD significantly changed the governance of the MHS under a new Defense Health Agency that consolidated non-clinical functions beginning October 1, 2013. According to the DoD, the DHA could save the government between $1.5 to $2.9 billion over the next six years through consolidation and standardization of ten shared support functions among the Services, increased oversight of six

multi-service (Joint) markets and other cost-saving measures.[23] However, the Government Accountability Office (GAO) found these estimates unsubstantiated.[24] The DoD has also taken steps to limit access to some benefits by eliminating or reducing some Prime Service Areas. However, Congress recently passed legislation to grandfather existing beneficiaries that will likely reduce savings estimates.[25, 26]

Moreover, there are even some in Congress, like Senator Lindsey Graham (R-SC), who believe increased cost-shares are needed in order to keep TRICARE afloat.[27] The DoD has been trying to raise retiree cost-shares through increases to baseline TRICARE enrollment fees[28] and the introduction of new fees for TRICARE Standard, Extra and TFL. These proposals intended to bring beneficiary cost-shares closer to original levels mandated by Congress when the program was established.[29] Enrollment fee increases were also recommended by the 2007 Task Force on the Future of Military Healthcare.[30]

The Congressional Budget Office projected that savings from enrollment fee changes would be "billions of dollars."[31] However, this approach has drawn a lot of fire from many members of Congress and retiree groups intent on fighting any additional costs for military retirees.[32,33] The recently passed National Defense Authorization Act for Fiscal Year 2014 rejected all proposed TRICARE fee changes.[34]

Latest Proposal by the Congressional Budget Office (CBO)

In January 2014, the CBO proposed three options to reduce federal spending on military health care.[35] Option one increases cost-shares for working-age retirees. Option two makes working-age retirees and their families ineligible for TRICARE Prime, but allows them to continue using other TRICARE plans after paying a new annual fee. Finally, option three introduces minimum out-of-pocket requirements for Medicare-eligible retirees and their family

members (generally those over 65) to access TRICARE for Life. The CBO concludes that savings from implementing these proposed changes would range between $20 and $60 billion over the next 10 years.

Competition for limited DoD dollars challenge the sustainability of the status quo and will likely drive these type of cost reduction strategies into mainstream thinking unless the MHS can provide the DoD some politically viable alternatives.

Potential Increases in Out-of-Pocket Beneficiary Payments a "Broken Promise?"

Under current law, active-duty personnel are entitled to military health care and have a right or claim to this care.[36] Active duty dependents are also entitled to care, however, this entitlement is limited to space or service availability restrictions. Retirees and their dependents, while eligible for care on a space- or service-available basis, have no statutory entitlement to such care. In theory, DoD could choose not to provide health-care benefits to retirees and retiree dependents.[37]

Retiree advocacy groups maintain they were promised free health care for life even though the courts and Congress have both definitively determined that the promise of free health care for life was never enforceable.[38] This begs the question—is there a way to reduce DoD health-care expenditures while lessening political resistance at the same time? Perhaps employers of retirees are part of the solution.

How Do Employers Fit Into the Equation?

Recommendation #11 by the 2007 Task Force on Military Healthcare states "DoD should commission a study, and then possibly a pilot program, aimed at better coordinating insurance practices among those retirees who are eligible for private health-care insurance as well as TRICARE."[39] The Task Force made it clear that they believed any study should give retirees the

option to choose either TRICARE or an employer-sponsored plan.

DoD Already Coordinates (Somewhat) with Employer-Sponsored Plans

Military retirees who work may be afforded health-care benefits from their employer. A retiree who opts into an employer-sponsored plan is still eligible for any of the TRICARE plans; however, health-care claims submitted on behalf of the retiree will first be processed through the employer-sponsored insurance provider also referred to as other health insurance (OHI). After the OHI carrier adjudicates the claim, TRICARE will pay the balance up to the amount TRICARE would have paid had there been no OHI.[40]

Retirees who have OHI help offset DoD health care expenses in at least two ways. First, given that 98% of employer-sponsored health insurance has an actuarial value of 80% or greater,[41] the DoD is responsible for only about 20% of the TRICARE maximum allowable charge. This combination of coverage also means the retiree often has little or no out-of-pocket expenses associated with his or her care.

Secondly, MTFs that provide care to beneficiaries with OHI have the right to collect from that beneficiary's other insurance the cost of the health care provided.[42] Between FY 2001 and 2012, the MHS collected just over $1.8 billion from OHI.[43] Unfortunately, as the U.S. economy has faltered collections have dropped due to an increase in the number of beneficiaries either not eligible for or opting out of OHI and relying solely on TRICARE.

Employers and Retirees Benefit from Existing Rules

Since the early 1940's, employers have been voluntarily providing health insurance benefits to employees as part of compensation packages.[44] With the passage of the Patient Protection and Affordable Care Act, this long-standing business practice has been codified into federal law for many employers.[45] According to the Kaiser Family Foundation, the average

annual premium for family coverage in 2012 was $15,745[46] with the employee share being $4,102,[47] or roughly 26% of the cost. Therefore, every retiree who opted out of his or her employer-sponsored plan saved the employer around $11,643 in premium payments.

By opting out of employer-sponsored plans, retirees also save since they avoid paying the employee cost-share portion of health insurance premiums. Those savings are marginally reduced by the total cost of their TRICARE plan. For example, in 2012 the average retiree cost-share for TRICARE Prime was $965 or less than one-quarter of the civilian employee cost-share.[48] This represents an average cost-share savings for the retiree of $3,137 per year.

Congress Attempted to Curb Employer Inducements

In 2007, Congress tried to stop employers from incentivizing retirees from opting out of OHI. Section 707 of the 2007 NDAA restricted the ability of employers to offer targeted subsidies and other incentives to military retirees for agreeing to forego employer-sponsored plans.[49] However, it did not prohibit retirees from voluntarily opting out of employer-sponsored plans. Also, there are still instances where military retirees may be offered financial incentives to opt out as long as those incentives are not restricted solely to TRICARE beneficiaries.[50]

According to the final rule in the Federal Register, the purpose of this prohibition on incentives is to prevent employers from "*shifting their responsibility for their employees*" onto the federal taxpayers.[51] A report by the GAO in 2011 found that the impact of Section 707 could not be determined; however, working-age retiree OHI coverage is clearly trending down.[52] The rate of decline has slowed from 8% per year during 2001-2007 to 6% per year during 2008-2012. Finally, since 2007 the number of retirees under age 65 has dropped by 2%, but the number of retirees under age 65 enrolled in TRICARE Prime has increased by 17%.[53] This suggests Section 707 may have had a marginal effect, but did not do enough to reverse the decline in private

health insurance coverage.

Policy Options for DoD Consideration

Congress believes it has already put TRICARE on a sustainable path through reforms in several recent NDAAs.[54] However, budgetary pressure and the need to maintain a decisive military advantage in all warfighting domains demands that the MHS be part of the fiscal solution. Specifically, the MHS must provide politically viable options to the DoD in order to help it rebalance where money is being spent internally.

Although the political landscape may not support an increase to *baseline* TRICARE fees, I have developed three options designed to spread the cost of providing health care to retirees among the DoD, employers and working retirees. However slight, there appears to be some political will for fiscal offsets from working-age retirees as evidenced by the 2014 budget deal that reduced the COLA for working-age retirees.[55]

Option #1: Mandating Working Retirees to Opt into Employer-Sponsored Plans

DoD could propose mandating working-age retirees opt into employer-sponsored health insurance while making access to TRICARE benefits contingent upon that enrollment or certification of non-availability. Employers would be prohibited from differentiating between employees with and without a military retirement. This option is different than the CBO option recently proposed in that it preserves retiree eligibility for TRICARE Prime. The CBO option makes all working-age retirees ineligible for TRICARE Prime regardless of employment status or OHI. Unlike my proposal, the CBO option does not make access to other TRICARE plans contingent upon enrollment in OHI; however, it does establish fees for TRICARE Standard and Extra—a proposal that has already been rejected by Congress.

Under this option, employers who provide health insurance to their employees

voluntarily, or as required by law,[56] would pay health insurance premiums to their insurer for a military retiree at the same level and to the same extent as similarly situated employees who are not TRICARE eligible. Once the retiree satisfies the proposed contingency clause by enrolling in OHI, the retiree would then be eligible to register for *any* TRICARE plan subject to existing rules and fee structures. Implementation of this option will require a new registration and OHI verification process for working-age retirees who rely on TRICARE Standard and Extra. It may be possible to automate this process using federal tax records.

The DoD could save more than $15 billion across the FYDP by effectively making TRICARE a final payor for working-age retirees while still preserving this rich benefit as a safety net for retirees who do not have access to OHI (appendix B-6). Additionally, as more than half of working-age retirees are eligible under a spouse's health insurance coverage,[57] DoD may consider incentivizing military retirees who do not have access to OHI through their employer to enroll in their spouse's plan.

Retirees may view this option as a broken promise because eligibility for TRICARE becomes contingent upon enrollment in their employer's plan. This may even drive some retirees out of the workforce and back onto the rolls of TRICARE. This contingency clause is similar to the current contingency rules associated with TFL eligibility with respect to Medicare Part B.

Option #2: Employer Payments to TRICARE

DoD could propose a rule requiring employers of working-age retirees who opt out of employer-sponsored plans to pay TRICARE the same amount of premium the employer would have otherwise paid to their insurer if the retiree were insured under their plan. The premium amount would represent the same level of benefits as similarly compensated employees who are not TRICARE eligible.

Like option #1, this option also eliminates the financial benefit employers enjoy today under the current system. Politically, this may be the most attractive option because it is ***cost neutral for working-age retirees*** although large employers who employ a significant number of retirees may object. Fiscally, this could save $41 billion across the FYDP or about as much as the CBO option that strips retirees of TRICARE Prime benefits (appendix B-7).

Retirees may argue this proposal makes them less attractive to employers because employers have to pay health insurance premiums for the retiree—a benefit he or she may feel has already been *earned*. Notwithstanding the entitlement argument mentioned previously, I submit TRICARE eligibility hardly registers as a cost consideration in the calculus of the majority of employers in the U.S. who provide health insurance to their employees. Military retirees make up less than 1.5 percent of the active U.S. workforce.[58] In order to attract the most qualified candidates, employers will continue to offer competitive benefit packages. Nearly 80% of employers of military retirees (pre-ACA) offer employer-sponsored health benefits.[59]

Retirees may also argue that requiring employers to make premium payments to TRICARE will negatively impact the salary they are able to negotiate. Today, retirees can legitimately use access to low-cost TRICARE plans as a lever to negotiate higher salaries since employers save on insurance premium costs. Moving forward, DoD needs to decide whether or not it wants to continue to underwrite this practice.

Finally, retirees may argue employers will relegate them to part-time status en masse because the employer has to make premium payments to TRICARE. Alternatively, retirees may actively seek part-time status (where benefits are not required under ACA) in order to negotiate a higher salary with the employer and still avoid this proposed rule. To the first point, since military retirees make up such a small percentage of the U.S. workforce any substantial shifts in

the number of full-time employees will likely be attributable to other economic factors with broader impact such as the Affordable Care Act.[60] On the second point, adopting option #3 below in conjunction with this option could mitigate this concern as it would apply to both full- and part-time retirees under age 65 without access to OHI.

Option #3: Cost-Share Based on Wages <u>Above Retired Pay</u> for Retirees Under Age 65

DoD could propose a cost-share (i.e., 2.95% in 2014 that would gradually increase to 4.00% in 2018 then remain constant[61]) against wages above retired pay for working retirees under age 65 who either voluntarily opt out of employer-sponsored health insurance plans or are neither offered nor eligible for OHI. The cost-share would apply only to wages above retirement pay and it would not be subject to the cap proposed in the 2014 DoD budget submission. The percentages proposed above were determined to bring working-age retiree cost-shares closer to that of their civilian counterparts.[62] Under this option, the current baseline TRICARE enrollment fees are not impacted and no new fees are proposed for TRICARE Standard or Extra (as was proposed in the latest CBO options). Furthermore, this cost-share does not distinguish between different TRICARE plans because that variation is already accounted for in the existing baseline TRICARE fee structure.

Under this option, the retiree is in the best position to compare coverage and costs between their employer-sponsored plan and any available TRICARE plan. Fiscally, this option could save the DoD more than $7 billion across the FYDP (appendix B-9) and improve cost-share parity between TRICARE plans and the average employer-based plan.[63] It also improves the cost-share parity among retirees as a function of (non-retirement) wages.

Retirees may argue that benefits earned during military service have nothing to do with their post-retirement wages. However, as discussed previously, retirees are not entitled to health

care. The DoD chooses to provide access to subsidized health-care benefits to retirees. To date, DoD has chosen to provide the same subsidy to all retirees regardless of financial means or secondary sources of income—a luxury DoD may no longer be able to afford.

This option would make the cost of TRICARE more equitable among retirees. I hesitate to use the word equal because current TRICARE cost-shares are independent of retirement pay. This means that today an E-6 who retires after 20 years pays about 7% of his or her retirement pay for TRICARE Prime while an O-6 with the same 20 years of service pays roughly 3%.[64] Additionally, if they both work after military retirement, the O-6 is likely to earn more than the E-6 due to training, education and experience, which would result in an additional cost-share gap. To minimize the effect on lower-income retirees, DoD could propose minimum secondary wage thresholds as they relate to TRICARE fees (i.e., apply to secondary wages starting above $10,000 or apply if retirement income plus secondary wages exceed $50,000, etc.).

Prohibition on Employer Cash Payments to Retirees in Lieu of Health Insurance

In order for any of these options to be effective, DoD could propose prohibiting the employer from offering cash payments to the retiree in lieu of providing health-care coverage—a provision that is currently allowed under Section 707 of the 2007 NDAA.[65] By prohibiting cash payments, retirees would be less incentivized to opt out of employer-sponsored plans. Without addressing this statute, these proposed options will be less effective. For example, today retirees can legitimately accept a cash payment (e.g., $2,000), opt out of an employer-sponsored plan, and then enroll in TRICARE. Alternatively, DoD could propose cash payment opt-out incentives be directed to DoD (variation of option #2 above).

Retirees may view eliminating the cash-payment provision as an erosion of their benefits, and insofar as the cash payments do not exceed the cost of any TRICARE supplemental

insurance coverage plus any TRICARE cost-shares, the argument has merit for the retiree.[66] Under the cash payment provision, however, the employer pays only a fraction of the health insurance premiums it would have otherwise paid to their insurer and effectively shifts the bulk of the health-care expense risk to the taxpayer.

Recommendation

Given the effects of fiscal pressure on the DoD, the MHS must find politically viable ways to help address the budget crisis. Sustained efforts by DoD to increase baseline TRICARE fees have not been supported by Congress, yet the DoD continues promoting this strategy.

Instead, I propose DoD implement a combination of options #2 and #3 described above. I recommend option #2 because it is cost-neutral for retirees, generates a substantial amount of revenue and is aligned with the intent of Section 707 of the 2007 NDAA. DoD need not collect the entire subsidy, but could consider some variant such as employer payments to TRICARE that are less than the amount the employer would have paid to the insurer. It may also consider phasing-in the amount over time. Both alternatives would reduce the savings estimates. Additionally, I recommend option #3 also be implemented because it raises additional revenue while increasing cost-share parity among retirees.

To make these recommendations effective, the DoD should also propose modifications to Section 707 of the 2007 NDAA, such as removing the cash payment 'opt out' option previously discussed. Although this change would not force retirees to opt into employer-sponsored plans, it may help maintain the current level of OHI or slow the declining rate of OHI among working-age retirees.

By accepting my recommendations, the DoD can save up to $48 billion across the FYDP while improving the fairness of the system. Although Congress has generally frowned upon

increased cost-shares for retirees, DoD may have more success leaving baseline TRICARE fees alone and promoting the idea of cost-share parity among working-age retirees with respect to wages above retirement pay. Furthermore, since these options have not yet been considered by the DoD, they do not face the stigma attached to previous DoD proposals.

In proposing these options, DoD should reaffirm its commitment to the preservation of the military retiree's right to choose between an employer-sponsored plan or TRICARE. DoD should also clearly affirm to Congress the position that employers are responsible for providing health-care insurance to their employees regardless of TRICARE eligibility. This position is consistent with Congressional testimony and current law.[67]

Way-Ahead

I am confident the leaders of the MHS will make rational programmatic choices based on their constraints, but I fear significant forced cuts for the direct-care system could have unintended, long-lasting, negative consequences to military readiness. Moving forward, the DoD must continue to look for new ways to increase efficiency within the MHS, including: increased sharing of DoD-VA infrastructure personnel, and patients; further exploring consolidation of common services; increasing in-house care productivity, and holistic care protocols designed to reduce utilization rates and improve health. Still, these will not be enough.

Even though I posited that the MHS is controlling costs effectively and is economically efficient relative to theoretical alternatives, it still finds itself having to resort to significant cost-cutting. Implementing the options I have laid out will put the MHS on a sounder fiscal footing through increased revenues without having to resort to potentially draconian measures.

Moreover, my recommendations will have a measured impact to working-age retirees and keep baseline TRICARE fees at established levels. Pursuing these options will help provide time

for more deliberate strategic planning and give the MHS the fiscal trade-space it needs to sustain both a medically ready force and a ready medical force.

Notes

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